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# Union Gospel Mission

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## Application for Union Gospel Mission's Men's Addictions Recovery Program

### Instructions for Completing this Application

- 1.) Complete all areas of this application so it can be processed
- 2.) Some areas of this application require you to circle yes, or no, or to circle all that apply
- 3.) Please review the application when completed and then bring it in person, fax, or email it to Union Gospel Mission

### General Information

Date of Application \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

Applicant's Name \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Surname Middle Name Given Name

Date of Birth \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Highest Education Level Achieved \_\_\_\_\_  
Day Month Year

Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye Colour \_\_\_\_\_ Hair Colour \_\_\_\_\_ Eye Glasses Required (Circle) Yes, or No

Treaty Status (Circle) Yes, or No Band Name \_\_\_\_\_ Treaty Number \_\_\_\_\_

Relationship Status (Circle All That Apply) Single, Married, Common-Law, Separated, Divorced, Widowed

Telephone Numbers 1.) (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ 2.) (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Current Address \_\_\_\_\_

What is your Housing Situation? (Circle) Renting, Own Home, or Other Please Explain \_\_\_\_\_

Are you on Employment Income Assistance (EIA)? (Circle) Yes, or No Please Explain \_\_\_\_\_

Contact Person \_\_\_\_\_, \_\_\_\_\_ Relationship to You \_\_\_\_\_  
Surname Given Name

Telephone Numbers 1.) (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ 2.) (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Have you previously filled out an application for Union Gospel Mission's Men's Recovery Program? (Circle) Yes, or No

If Yes, what was the approximate date of the application? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

Have you previously been accepted into Union Gospel Mission's Men's Recovery Program? (Circle) Yes, or No

**Union Gospel Mission Men's Recovery Program**

If Yes, what was the date of residency? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

Which Recovery Chaplain were you assigned to? \_\_\_\_\_, \_\_\_\_\_  
Surname Given Name

Who referred you to Union Gospel Mission? \_\_\_\_\_, \_\_\_\_\_  
Surname Given Name

Telephone Numbers 1.) (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ 2.) (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Email Address \_\_\_\_\_

Do you have relatives, or friends who are residents at the Union Gospel Mission Men's Recovery Program? (Circle) Yes, or No

Name \_\_\_\_\_, \_\_\_\_\_ Name \_\_\_\_\_, \_\_\_\_\_  
Surname Given Name Surname Given Name

Do you know anyone who was a previous resident at the Union Gospel Mission Men's Recovery Program? (Circle) Yes, or No

Name \_\_\_\_\_, \_\_\_\_\_ Name \_\_\_\_\_, \_\_\_\_\_  
Surname Given Name Surname Given Name

Why do you want to live and participate in the Union Gospel Mission Men's Recovery Program?

Please Explain \_\_\_\_\_

What would you like to accomplish during your stay with Union Gospel Mission? What are some of your Goals?

Please Explain \_\_\_\_\_

Do you agree to participate in a Biblically-based recovery program? (Circle) Yes, or No

What is your church affiliation? \_\_\_\_\_ List any previous church involvement \_\_\_\_\_

**Physical Health**

Do you have any specific health problems? (Circle) Yes, or No If Yes, Please Explain \_\_\_\_\_

Date of last physical \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Date of last dental exam \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Day Month Year Day Month Year

Do you have any immediate medical needs such as allergies, or medical conditions? (Circle) Yes, or No

If Yes, Please Explain \_\_\_\_\_

List Current Medical Appointments \_\_\_\_\_

Do you have any immediate medication needs? (Circle) Yes, or No

If Yes, Please Explain \_\_\_\_\_

List all medications you are currently taking on the sheet provided at the back of the application form.

Do you have any Scars? (Circle) Yes, or No If Yes, Please Explain \_\_\_\_\_

Do you have any Tattoos? (Circle) Yes, or No If Yes, Please Explain \_\_\_\_\_

Union Gospel Mission Men's Recovery Program

Mental Health

Do you experience any mental health issues? (Circle) Yes, or No

Have you been diagnosed? (Circle) Yes, or No

Please Specify \_\_\_\_\_

Schizophrenia (Circle) Yes, or No

Depression (Circle) Yes, or No

Anxiety (Circle) Yes, or No

Mood Disorders (Circle) Yes, or No

Post-Traumatic Stress Disorder (Circle) Yes, or No

Other (Circle) Yes, or No

Please Explain \_\_\_\_\_

Do you currently have an Eating Disorder? (Circle) Yes, or No

If Yes, Please Explain \_\_\_\_\_

Have you had an Eating Disorder in the Past? (Circle) Yes, or No

If Yes, Please Explain \_\_\_\_\_

Have you ever attempted suicide? (Circle) Yes, or No

If Yes, Please Explain \_\_\_\_\_

If Yes, date of last attempt \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

Have you been hospitalized for a suicide attempt? (Circle) Yes, or No

If Yes, where did or do you receive treatment? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

Date of last appointment \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

Psychiatrist \_\_\_\_\_, \_\_\_\_\_  
Surname Given Name

Telephone Number (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Psychologist \_\_\_\_\_, \_\_\_\_\_  
Surname Given Name

Telephone Number (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Counsellor \_\_\_\_\_, \_\_\_\_\_  
Surname Given Name

Telephone Number (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Manitoba Health Card - M.H.C. (6 Digit Number) \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

Personal Health Identification Number - PHIN (9 Digit Number) \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

Doctor's Name \_\_\_\_\_, \_\_\_\_\_  
Surname Given Name

Telephone Number (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Clinic Name \_\_\_\_\_

We require residents to do daily chores. Can you participate in the chore system? (Circle) Yes, or No

Do you have any physical limitations? \_\_\_\_\_

Please note, failure to comply with chore requirements as arranged could result in being asked to exit the program.

Union Gospel Mission Men's Recovery Program

Abuse

Have you been sexually abused? (Circle) Yes, or No In childhood (Circle) Yes, or No In adulthood (Circle) Yes, or No

Did you receive treatment? (Circle) Yes, or No Have you ever received mental health counselling? (Circle) Yes, or No

Have you ever been in an abusive relationship? (Circle) Yes, or No If Yes, describe the abuse \_\_\_\_\_

Please Explain \_\_\_\_\_

Name \_\_\_\_\_, \_\_\_\_\_ What is their relationship to you? \_\_\_\_\_
Surname Given Name

Current Restraining Order (Circle) Yes, or No If Yes, Please Explain \_\_\_\_\_

Name \_\_\_\_\_, \_\_\_\_\_ Terms of restraining order \_\_\_\_\_
Surname Given Name

Date the restraining order was issued \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
Day Month Year

Addiction History

Do you use Alcohol? (Circle) Yes, or No Frequency of use (Circle all that apply) Daily, Binge, or Other

How long have you consumed Alcohol? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
Days Weeks Months Years

When was your last drink? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
Day Month Years

What is your longest period of sobriety? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
Days Weeks Months Years

How long have you used? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
Days Weeks Months Years

Last use? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Longest clean? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
Day Month Year Days Weeks Months Years

What substances have you used? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

What is your drug of choice? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Do you Smoke? (Circle) Yes, or No How long have you been Smoking? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
Days Weeks Months Years

Do you Gamble? (Circle) Yes, or No How long have you been Gambling? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
Days Weeks Months Years

Have you ever completed a Drug or Alcohol Treatment Program? (Circle) Yes, or No

Date \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Program Name \_\_\_\_\_
Day Month Year

Location \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
Town, or City Province Country

Union Gospel Mission Men's Recovery Program

Personal Supports

Other Sources of Income (Circle all that apply)

Employment Income Assistance EIA (Circle) Yes, No, or Pending

Disability Claim (Circle) Yes, No, or Pending Private (Circle) Yes, or No Band (Circle) Yes, or No Other (Circle) Yes, or No

Please Explain \_\_\_\_\_

Employment Income Assistance EIA Number \_\_\_\_\_ Direct Deposit (Circle) Yes, or No

Employment Income Assistance EIA - Worker

Name \_\_\_\_\_, \_\_\_\_\_ Telephone Number (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_
Surname Given Name

Email Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

Upcoming Employment Income Assistance EIA Appointment? (Circle) Yes, or No

If yes, what date? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
Day Month Year

Have you ever been convicted of criminal charges? (Circle) Yes, or No

Arson (Circle) Yes, or No Sexual Offence (Circle) Yes, or No Fraud (Circle) Yes, or No Racketeering (Circle) Yes, or No

Kidnapping (Circle) Yes, or No Embezzlement (Circle) Yes, or No Insider Trading (Circle) Yes, or No Theft (Circle) Yes, or No

Please list the dates and offenses of your criminal record

Date \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Offense \_\_\_\_\_
Day Month Year

Date \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Offense \_\_\_\_\_
Day Month Year

Date \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Offense \_\_\_\_\_
Day Month Year

Date \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Offense \_\_\_\_\_
Day Month Year

Current Criminal Charges (Circle) Yes, or No Please Explain \_\_\_\_\_

Are you on Bail? (Circle) Yes, or No

Are you currently on Probation? (Circle) Yes, or No

Parole Officer

Name \_\_\_\_\_, \_\_\_\_\_ Telephone Number (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_
Surname Given Name

Email Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

**Union Gospel Mission Men's Recovery Program**

**Lawyer**

Name \_\_\_\_\_, \_\_\_\_\_ Telephone Number (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_  
Surname Given Name

Email Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

List all upcoming court dates and appointments with your Parole Officer, your Lawyer, and etcetera. (Briefly explain each)

\_\_\_\_\_  
\_\_\_\_\_

**Children and Dependents**

If applicable, please provide the following information. The name, birth date, age, current custody arrangements of your children under 18 years of age.

Surname, Given Name	Gender	Birth Date	Age	Current Custody Arrangements

**Child and Family Services CFS Worker**

Name \_\_\_\_\_, \_\_\_\_\_ Telephone Number (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_  
Surname Given Name

Email Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

**Upcoming Child and Family Services CFS Court Dates**

\_\_\_\_\_

**Child and Family Services CFS - Lawyer from Child and Family Services**

Name \_\_\_\_\_, \_\_\_\_\_ Telephone Number (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_  
Surname Given Name

Agency Name \_\_\_\_\_

Email Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

**Union Gospel Mission Men's Recovery Program**

**Medications**

Please use this space to list all medication you are currently taking.

Medication Name	Purpose	Dosage	Frequency

**Please Read Carefully** Union Gospel Mission is a Drug, and Alcohol Free Environment. We will do Random Drug and Alcohol Testing. We do not allow residents to use any type of Alcohol, or Substance. It is your responsibility to remain clean and sober while you reside at the mission. Failure to do so will result in being asked to exit the program immediately.

**Can you comply with these rules?** (Circle) Yes, or No

**Please Print,** I, \_\_\_\_\_, \_\_\_\_\_ verify that all the information that I have submitted in this  
Given Name Surname  
application accurately reflect my present situation. I understand that failure to disclose all pertinent information, or falsification of facts contained within this application may result in my immediate departure from the Union Gospel Mission's Men's Recovery Program. Please sign this document if you are in agreement with the above information.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

**Thank You for Completing this Application**

- Please take note that you are taking a step in the right direction
- Know that God loves you and there are people who want to see you live sober and do well
- Review the completed application and then bring it in person, or email it to Union Gospel Mission

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## For Office Use Only

Do Not Write on This Page

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The Application Summary Below is to be Completed by a Chaplain Team Member

Date of Application \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

Name \_\_\_\_\_, \_\_\_\_\_ Date of Birth \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Surname Given Name Day Month Year

Telephone Number (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ Message Left \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

Date of Interview \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Date of Admission \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Day Month Year Day Month Year

Admission Accepted (Circle) Yes, or No Time of Admission (Circle) 10:00 AM, or 11:00 AM

Financial Arrangements Completed (Circle) Yes, or No Source (Circle) Private, EIA, or Pending

Tested Clean at Admission (Circle) Yes, or No Tested Positive for Medication (Circle) Yes, or No

Reason if Application was not accepted \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Staff that were present during application interviews - Resident Supervisor, Princess Street Manager, or Chaplain

Please Print \_\_\_\_\_, \_\_\_\_\_ Signature \_\_\_\_\_  
Surname Given Name

Please Print \_\_\_\_\_, \_\_\_\_\_ Signature \_\_\_\_\_  
Surname Given Name

Please Print \_\_\_\_\_, \_\_\_\_\_ Signature \_\_\_\_\_  
Surname Given Name

Please Print \_\_\_\_\_, \_\_\_\_\_ Signature \_\_\_\_\_  
Surname Given Name